STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146141	A. Building B. Wing	05/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Terraces at the Clare	55 East Pearson Chicago, IL 60611

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined that the facility failed to ensure residents were free of physical restraints. Specifically, the facility failed to ensure one (R1) of three residents reviewed for restraints was free of physical restraints unless medically necessary in the sample of three. R1 was physically restrained with a blanket across the chest that was then tied to the frame of R1's bed.Findings include: Facility's final incident report of 5.24.2026, documents, in part: At approximately 5:45 am on 5.19.2026, a first shift CNA observed that the top left corner of the resident's blanket had been tied to the bed frame near the bed enabler closet to the hallway. The CNA informed the nurse. At approximately 6:15 pm, on 5.19.2026, the third shift CNA returned the DON's calls and texts and spoke with both the DON and Administrator. The CNA stated that she had secured the resident's blanket to the bed in an effort to prevent the resident from getting up independently and potentially falling. The third shift CNA acknowledged prior education and training on abuse prevention, including understanding that the use of physical restraints is considered abuse. The CNA also reported that she informed the nurse on duty of her actions.Based on the known facts, the following conclusions have been made about the original allegation: (V4-Former CNA-Certified Nursing Assistant) admitted that she deliberately tried to physically restrain the resident. The CNA is no longer an employee. (V5-LPN Licensed Practical Nurse) denied knowledge of the event and was assessed as credible.R1's medical record (Face Sheet) documents R1 is a [AGE] year-old female with diagnoses including, but not limited to: Unspecified dementia, unspecified severity, with other behavioral disturbance; unspecified diastolic (congestive) heart failure; paroxysmal atrial fibrillation; essential (primary) hypertension; hypothyroidism, unspecified; Meniere's disease, unspecified ear; major depressive disorder, recurrent, severe with psychotic symptoms; and anxiety disorder, unspecified. R1's MDS (Minimum Data Set-4.6.2026) documents a BIMS (Brief Interview for Mental Status) score of 10 indicating R1 is moderately cognitively impaired. R1's medical record (Care Plans, Assessments, Physicians Order Sheet) does not document an assessment, physician's order or care plan for a restraint.5.31.2026 at 9:30 AM, R1 said was unable to tell the surveyor what happened. 5.30.2026 at 1:03 PM, V1 (Administrator) said, V4 said she told V5 that she tied the blanket to R1's bed; V5 denied the allegation. We don't think he was aware of the situation. The blanket was tied to R1's bed frame, the enabler was closed. It wasn't visible until V6 (CNA-Certified Nursing Assistant) came into R1's room that morning to get R1 up.5.30.2026 at 2:19 PM via telephone, V6 (CNA) said, um, actually I was coming on (to work) at 6:00 AM. I worked my way down to R1's room. She's the first resident I get up. When I went to remove her cover, it was stuck. The blanket was tied on the bed frame that mattress sits on. It was tied on the side that she normally gets out of the bed. So, I was trying to untie it, but it was tied so tight I couldn't get it untied. I went to get the nurse. V5 (LPN) came into the room and was able to untie it. It seemed a little tough for him to remove. I really don't know where the other end was or if it was tied. I couldn't move the blanket. You don't do that to nobody, that's not acceptable. That's like trying to tie a dog down. I didn't like that, that's why I reported it. I think it's abuse. That's a restraint, were not supposed to restrain residents.5.30.2026 at 3:08 PM via telephone, V5 (LPN (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed Practical Nurse) said, I was informed at the beginning of shift by V4 (Former CNA Certified Nursing Assistant) that R1 was a little restless. I told her that's her baseline and sometimes she goes restless, we just need to make sure she's safe by ensuring the bed is in low position, do rounds every one to two hours and make sure resident is on her bed. R1 is at high risk for falls. Usually, I do rounds prior to going on break and I usually do rounds around 3:00 AM, I normally go on break anywhere from 12:30 AM -1:00 AM. Then after that I think I do rounds at 4:30 AM, that would be my last set. In the morning, um one of the CNAs (V6) notified me, she asked me to untie the knot. I went to R1's room. I thought at first it (blanket) was stuck. I proceeded to untie it, it was simple over and under knot, I'm not sure what you call it, tied to the top right corner of the bed frame. I can't say for sure if it was tied to the other side, I can't say that I checked the other side. The blanket was tied to the bed at the level of R1's chest, it covered R1's chest. It (blanket) should not be tied to the bed because that would restrict her movement. We don't do restraints, anything that is tied on the bed is a restraint, anything that impedes her movement from doing what she wants is a restraint. The CNA could have let me know so that I could spend more time with the resident, that's the only way we make sure she stays safe.5.30. 2026 at 3:57, V2 (DON-Director of Nursing) said, I got a call from V6 (CNA) while I was on my way in to work (incoming call at 7:18 am per cell phone call log). V6 said she needed to speak with me but preferred not to speak with me on the phone. We agreed to meet/speak on the 16th floor. At approximately 8:45 AM, I spoke with V6. She said when she came in for her shift, a blanket was tied to one side of R1's bed, she couldn't get it untied. I immediately let V1 know. When I spoke with V4, she said she tied one side of the blanket to the bed, the other side she tucked in to prevent R1 from falling. I immediately told her, You can't do that, it's a restraint. V4 should have notified the nurse that V4 was having trouble redirecting the resident. V5 could have notified the On Call Supervisor to talk about other possible interventions if the behavior continued.Numerous attempts were made to contact V4 via phone and text (5.30.2026 at 2:34 PM,5.31.2026 at 10:18 AM, 5.31.2026 at 10:19 AM. V4 did not respond to surveyor's calls/text.V5?s Employee Behavioral Change Notice (5.23.2026) documents, in part: Behavioral Change Subject: Final Warning. Reason For Discipline: Safety, Work Performance, Policy Violation. V5 was involved in a review related to an abuse investigation on 5.19.26. It was identified that a CNA engaged in an inappropriate care practice (tying a blanket to one side of the bed) and the nurse (V5) was unaware of the action. Contributing factors included low visibility (dark room) and lack of direct supervision at the time of care. This reinforces the nurse's responsibility for supervision and accountability of CNA care delivery.Expectation (proof of awareness of expectations): It is the policy of (facility) to ensure all residents are free from abuse. A key responsibility of leadership and licensed staff is to provide consistent supervision and oversight of resident care to ensure safe, compliant practices are followed at all times.Moving forward, it is expected that you will:-Maintain active supervision and oversight of CNAs during resident care-Remain visibly engaged and aware of care being provided on the floor-Ensure resident care activities are performed safely, appropriately, and in accordance with policy-Intervene immediately when unsafe, noncompliant, or inappropriate practices are observed-Promptly report concerns, incidents, or policy violations to leadership-Promote a culture of accountability, resident safety, and professional supervision through consistent monitoring and leadership presenceStaffIllinois Long-Term Care Ombudsman Program Residents' Rights for People in Long-Term Care Facilities booklet (undated) documents, in part: Your rights to safety: You have a right to be free from physical or chemical restraints.Facility's Abuse Prevention Policy (Reviewed December 22, 2025) documents, in part: The (Facility) affirms the right of its residents to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This Community therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents.